United Nations ST/IC/1999/41

Secretariat

28 May 1999

Information circular*

To: Members of the staff at Headquarters

From: The Controller

Subject: **Renewal of the Headquarters medical and dental insurance plans effective 1 July 1999, and annual enrolment campaign, 7–11 June 1999****

General

1. The purpose of the present circular is to announce:

(a) A two-month premium rebate for participants in both the Aetna and Blue Cross plans (for details regarding administration of the rebate, see para. 7);

(b) Changes in the premium and contribution rates for the medical and dental plans offered at Headquarters (Aetna PPO, Blue Cross PPO, HIP HMO, Kaiser HMO and CIGNA dental PPO) which will come into effect on 1 July 1999 (see chart on p. 2);

(c) Modifications in the benefit structures of the Aetna and Blue Cross plans designed to bring the two PPOs into greater alignment. Thus, the annual deductible, individual and family annual out-of-pocket limits, hospitalization pre-registration requirements and several other benefits and provisions will henceforth be identical in both plans (for an outline of the relevant details, see the Aetna plan summary commencing on p. 9 and the Blue Cross plan summary commencing on p. 23);

(d) A change in the reimbursement level under both the Aetna and Blue Cross plans for prescription drug expenses incurred at non-network pharmacies from 80 per cent to 60 per cent;

(e) The annual opportunity for dental plan participants to switch from Option A to Option B, or vice versa, under the CIGNA dental PPO plan (see the CIGNA plan summary commencing on p. 39).

2. Annexes I to IX to the present circular set out plan outlines and benefit summaries. They are listed in paragraph 20.

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* Expiration date of the present information circular: 30 June 2000.

** *Personnel Manual* index No. 6170.

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Headquarters medical and dental insurance schedule of monthly premiums[a] and contribution rates[b] (Effective 1 July 1999)

Type of coverage	Aetna Open Choice		Blue Cross BlueChoice		HIP HMO		Kaiser HMO		CIGNA Dental with Medical Plan		CIGNA Dental alone
	1998 rates	1999 rates	1998 rates	1999 rates	1998 rates	1999 rates	1998 rates	1999 rates	1998 rates	1999 rates	1999 rates
Staff member only											
Premium rate ($)	319.34	336.25	229.84	229.84	185.13	197.88	214.63	265.85	23.14	33.00	33.00
Contribution rate (%)	2.76	2.82	2.00	1.94	1.62	1.68	1.85	2.22	0.19	0.26	0.39
Staff member and one child											
Premium rate ($)	614.51	670.90	458.60	458.60	366.49	391.74	429.28	531.68	55.15	66.00	66.00
Contribution rate (%)	4.66	4.94	3.53	3.42	2.69	2.78	3.28	3.94	0.39	0.46	0.69
Staff member and spouse											
Premium rate ($)	614.51	670.90	458.60	458.60	366.49	391.74	429.28	531.68	55.15	66.00	66.00
Contribution rate (%)	4.66	4.94	3.53	3.42	2.69	2.78	3.28	3.94	0.39	0.46	0.69
Staff member and two or more eligible family members											
Premium rate ($)	775.05	839.50	665.84	665.84	540.58	577.82	579.51	707.14	115.59	122.00	122.00
Contribution rate (%)	5.24	5.51	4.53	4.39	3.59	3.72	3.88	4.59	0.77	0.79	1.19

[a] The cost of the medical/dental insurance plans at Headquarters is shared between the participants and the Organization. Staff members may determine their exact contribution by multiplying their "medical net" salary (see below) by the related percentage of salary.

[b] "Medical net" salary for insurance contribution purposes is calculated as gross salary, less staff assessment, plus language allowance, non-resident's allowance, post adjustment or the variable element of monthly subsistence allowance, as applicable. Actual contributions are capped at 85 per cent of the corresponding premium.

Annual enrolment campaign

3. The annual enrolment campaign at Headquarters will be held from 7 to 11 June 1999 at the offices of the Insurance, Claims and Compensation Section (ICCS) of the Office of Programme Planning, Budget and Accounts, room S-2765, between the hours of 10 a.m. and 5 p.m. **Staff members at Headquarters must come in person to the Insurance, Claims and Compensation Section office to complete the application form and other forms as necessary**. The staff of the Insurance, Claims and Compensation Section will be available during the designated dates and hours to provide information and answer specific questions regarding the health plans being offered to staff. In addition, representatives of the insurance companies will be on hand on 7 and 8 June to provide information about the various insurance plans offered. The insurance company desks will be located in the staff activities area near the Secretariat cafeteria entrance.

4. Staff members are reminded that this will be the ***only*** opportunity until the month of June 2000 to enrol in the United Nations medical and dental insurance plans. This is also an opportunity to review current health insurance coverages within or outside the Organization and either enrol in one of the United Nations plans or apply for changes within these plans. Staff members who are satisfied with their coverage do not need to take any action at this time.

5. The medical and dental plans being offered during the June campaign and the pages on which plan outlines may be found are as follows:

(a) Aetna Open Choice (p. 9);

(b) Blue Cross BlueChoice (p. 23);

(c) Health Insurance Plan of Greater New York, Health Maintenance Organization (HIP/HMO) (p. 33);

(d) Kaiser Foundation Health Plan of the Northeast, Health Maintenance Organization (Kaiser/HMO) (p. 36);

(e) CIGNA Dental PPO plan (CIGNA) (p. 39).

6. The effective date of insurance coverage for all campaign applications, whether for enrolment, change of plan or change of family coverage, will be 1 July 1999. A change in enrolment between the Aetna and Blue Cross plans will oblige the participant to meet the annual out-of-network deductible in the new plan.

Premium rebate for Aetna and Blue Cross subscribers

7. Owing to the favourable claims experience of the Aetna and Blue Cross plans in recent years, which has resulted in the accumulation of surplus funds, it has been decided to effect a two-month premium rebate to participants. The rebate will be implemented in two instalments, in August and September 1999. The amount of the rebate for each participant will equal the premium contributions which normally would be due for August and September, and will be reflected in the end-of-month payroll statements.

8. The criterion for eligibility to receive a premium rebate is that the participant must be enrolled in the health insurance plan concerned in the month in which the rebate is given and must also have been in the plan one year previously. In view of the fact that the rebate covers both Aetna and Blue Cross participants, the distribution criterion will take account of those staff members who switch from Aetna to Blue Cross, or vice versa, during the 1999 enrolment campaign. Accordingly, staff members who were enrolled in Aetna or Blue Cross in August 1998, and who continue to be in either plan in August 1999, will receive a rebate.

Similarly, staff members enrolled in either plan in September 1998 and who are in one of the two plans in September 1999 will receive a rebate.

Results of the health insurance satisfaction surveys

9. It will be recalled that in January 1998 and again in January 1999, a survey of the attitudes of staff members and retirees towards the Headquarters dental plan (1998) and the medical plans (1999) was conducted by a firm of consultants engaged by the United Nations. The dental survey conducted last year indicated that a majority of dental plan subscribers (both active and retired staff) favoured a plan change. This finding was an important factor underlying the decision last year to redesign the dental plan structure and the subsequent decision to offer the CIGNA dental PPO plan following a competitive tender to national-level dental plan insurance companies.

10. The information obtained from the medical plan attitude (or opinion) survey conducted earlier this year by the same firm of consultants indicated clearly that a significant majority of staff and retirees were satisfied with the medical plans offered at Headquarters. The response rate to the survey was 30 per cent, not quite as high as might have been wished for, but more than adequate to yield meaningful results. In contrast to the dental survey, 82 per cent of the respondents to the medical plan survey indicated that they were satisfied with their medical plan. The detailed questionnaire results also revealed that Aetna and Blue Cross subscribers, by a significant margin, favoured in-network providers for all or most of their medical needs, indicating that the PPO concept had been well established as a desirable medical plan model in the United Nations.

Outcome of competitive marketing exercise to identify a single PPO carrier

11. In the light of the fact that some 9,000 staff and retirees at Headquarters were enrolled in one or the other of the Aetna and Blue Cross PPO plans, a request for proposal was issued earlier this year to a number of major health insurance companies with nationwide PPO networks, including the incumbent carriers, Aetna and Blue Cross. The objective of the exercise, which was carried out with the assistance of Buck Consultants, was to establish whether it might be cost-effective and more efficient from a quality-of-service standpoint to replace the two PPO plans presently offered by a single PPO carrier. The detailed analysis of the results of the request for proposal, under several key evaluation criteria, led to the conclusion that it would not be to the advantage of the large community of PPO subscribers to replace the existing two-plan arrangement with a single PPO carrier at the present time.

12. Two main factors underlay the decision to retain the present arrangement. First, no single carrier at the present time had a PPO network of providers large enough to minimize the disruption that would be felt by subscribers whose medical providers were not in the new network. The second major factor concerned the relative state of flux which surrounds the health insurance market place in the United States at the present time. Developments in this area will guide future consideration of the feasibility of identifying a carrier with a sufficiently comprehensive national PPO network to meet the needs of the United Nations community. However, in preparation for this eventuality, the decision has been made to undertake some initial steps towards aligning the benefit structures of the Aetna and Blue Cross programmes, as indicated in paragraph 1 (c) above and further detailed in the respective plan summaries.

Eligibility and enrolment rules and procedures

13. By Secretary-General's bulletins ST/SGB/1997/1 and ST/SGB/1997/2, dated 28 May 1997, the Secretary-General introduced a new system for the promulgation of administrative issuances and information circulars. A separate administrative instruction will be issued in due course which will set out the eligibility criteria and enrolment rules and procedures governing all United Nations contributory health insurance plans. However, until the new administrative instruction is issued, the eligibility criteria and enrolment rules pertaining to the Headquarters medical and dental health insurance plans as set out in information circular ST/IC/1997/32 dated 28 May 1997 (paras. 7–16) will remain in effect. For the convenience of staff members and for ease of reference, these administrative provisions are recapitulated in annex VIII to the present circular.

Cessation of coverage of staff member and/or family members

14. The Insurance, Claims and Compensation Section should be notified immediately of changes in the staff member's family that result in a family member ceasing to be eligible, for example, a spouse upon divorce or a child marrying or taking up full-time employment. However, commencing this year, ICCS is initiating a procedure by which covered children who reach the age of 25 will be automatically dropped from the staff member's coverage at the end of the year in which they reach the age of 25. Other than with respect to the children reaching 25, the responsibility for initiating the resulting change in coverage (e.g., from "staff member and spouse" to "staff member only" or from "family" to "staff member and spouse") **rests with the staff member**. Staff members who wish to discontinue their coverage or that of an eligible family member under a United Nations plan for any other reason may do so at any time, although this is strongly discouraged. Such terminations of coverage should be communicated to the Insurance, Claims and Compensation Section directly. It is in the interest of staff members to notify the Insurance, Claims and Compensation Section promptly whenever changes in coverage occur in order to benefit from any reduction in premium contribution which may result. Any such change will be implemented on the first of the month following receipt of notification. No retroactive adjustments can be made as a result of failure to provide timely notification of any change to the Insurance, Claims and Compensation Section.

After-service health insurance

15. Staff members are reminded that, among the eligibility requirements for after-service health insurance coverage, the applicant must be enrolled in a United Nations scheme at the time of separation from service. A minimum of five years of prior coverage in a United Nations or specialized agency health insurance scheme is necessary to qualify for unsubsidized after-service health insurance participation and 10 years of prior coverage for subsidized participation. In both cases, the staff member must be 55 years of age or over as of the date of separation. It should also be noted that only family members enrolled with the after-service health insurance staff member at the time of separation are eligible for continued coverage under the programme. After-service participants are reminded that the restriction set out in paragraph 4 above, to the effect that staff members may switch from one insurance plan to another only during the period of the annual enrolment campaign, does not apply fully to them. Full details on the eligibility requirements and administrative procedures relating to after-service health insurance coverage are set out in administrative instruction ST/AI/394, dated 19 May 1994.

Conversion privilege

16. Participants who cease employment with the United Nations and are not eligible for after-service benefits may arrange for medical coverage under an individual contract. This provision applies to all medical plans currently offered. The conversion privilege means that the insurer cannot refuse to insure an applicant and that no certification of medical eligibility is required. In general, unless the separating staff member has had a history of poor health, exercising the conversion privilege will be more costly than acquiring new insurance coverage. **In addition, the conversion privilege does not mean that the same insurance premium rates or schedule of benefits in effect for the United Nations group policy will be offered in respect of individual insurance contracts**. It should be noted, moreover, that the conversion privilege may be exercised only for separating staff who continue to reside in the United States as the insurers cannot write individual policies for persons residing abroad. In all cases, the conversion privilege must be exercised **within 31 days of the date of separation**. Details concerning conversion to individual policies under Aetna and Blue Cross BlueChoice may be obtained from the Insurance, Claims and Compensation Section, room S-2765. Details concerning conversion to individual policies under the Health Insurance Plan of Greater New York (HIP) and Kaiser plans should be obtained from those companies directly. The dental plan does not have a conversion option.

Claims and benefit inquiries and disputes

17. Although the staff of the Insurance, Claims and Compensation Section is available to assist staff members in administrative matters concerning participation in the various Headquarters insurance plans and problematic claims issues, claims questions should always be taken up in the first instance directly with the insurance company concerned. The addresses and relevant telephone numbers of the insurance companies are listed in annex IX to the present circular.

18. Staff members are reminded that the plan descriptions set out in annexes I to V constitute summaries of the benefits available under the respective plans. Every care has been taken to ensure that the plan summaries are as comprehensive as possible. However, each of the plans is subject to certain exclusions and limitations which are set out in the respective plan description booklets and in the policy contract. In the event of a claim dispute with any of the insurance carriers or plan administrators concerned, the resolution of such dispute will be guided by the terms and conditions of the policy contract in question and the final decision will rest with the insurance carrier or plan administrator, not with the United Nations. The policy contracts with the insurance carriers or plan administrators are available for review by subscribers, as may be necessary, by appointment at the offices of the Insurance, Claims and Compensation Section, room S-2765.

Headquarters health insurance plans: outlines and summaries of benefits

How plans are costed

19. The United Nations policies with Aetna, Blue Cross and CIGNA are "experience-rated". This means that the premium cost each year of the Aetna, BlueChoice and CIGNA Dental plans is based on the level of claims incurred in the prior year and expected rates of utilization and medical cost inflation for the renewal period. In effect, the costs of these plans (claims incurred plus administrative expenses) are borne collectively by participants in these schemes. In a year following a period of heavy utilization, premium increases are likely to be relatively high. Conversely, if utilization in the prior year has been relatively moderate, the premium increase in the subsequent year will be correspondingly moderate. The two health maintenance organization (HMO) plans, HIP and Kaiser, are "community-

rated". This means the premium costs are based on the combined experience of all employers participating in these schemes, not just the United Nations, and are approved by the relevant state insurance authorities. It should be emphasized, particularly with respect to the three experience-rated plans, that prudent utilization by all participants concerned will have the effect of moderating premium costs for the benefit of all.

Plan outlines and benefit summaries

20. Outlines of the health insurance plans offered as well as summaries of benefits of each plan are set out in the following annexes:

		Page
I.	Aetna "Open Choice" Plan	8
II.	Blue Cross BlueChoice	20
III.	Health Insurance Plan of Greater New York/Health Maintenance Organization (HIP/HMO)	30
IV.	Kaiser Foundation Health Plan of the Northeast/Health Maintenance Organization	33
V.	CIGNA Dental PPO Plan	36
	In addition, information regarding the World Access emergency facility for Aetna and BlueChoice subscribers, a listing of participating Aetna and BlueChoice pharmacies as well as a listing of insurance carrier addresses and telephone numbers are set out in the following annexes:	
VI.	World Access	41
VII.	Aetna and Blue Cross Plans: list of participating pharmacies	42
VIII.	Eligibility and enrolment rules and procedures	44
IX.	Insurance carrier addresses and telephone numbers for claims and benefit inquiries	48

Finding PPO providers through the "Insurance" Web site

21. Lists of participating providers under the Aetna, Blue Cross and CIGNA PPO plans are available at the offices of the Insurance, Claims and Compensation Section (ICCS), room S-2765. In addition, staff members are encouraged to utilize the provider search facilities which can be accessed through the ICCS home page on the United Nations Intranet. Just click on "Insurance" under "Quicklinks" on the Intranet home page.

Annex I

Aetna "Open Choice" Plan

Plan outline

The Aetna Open Choice health benefits plan (Aetna) offers worldwide coverage for hospitalization and surgical, medical and prescription drug expenses. Under this plan, medically necessary treatment for a covered illness or injury may be obtained at a hospital or from a physician of one's own choosing, whether an in-network or non-network provider.

Aetna Open Choice is a dual-track plan that offers all the benefits of the traditional Aetna indemnity plan plus the option of a preferred provider organization (PPO) network of physicians and other medical providers nationwide. This means that participants can choose, if they wish, to go to a doctor who is in-network and pay only $10 per visit or treatment without any further need to file a claim with Aetna. Alternatively, participants may opt to receive treatment from any physician not in the network and be reimbursed by Aetna in the usual way, subject to the annual deductible and the normal co-insurance. A summary of the plan, both the in-network and the non-network (traditional indemnity) benefits, is set out in outline form commencing on page 12.

Under the non-network (traditional) track of the new Aetna plan, when a participant has met the annual deductible of $125 per individual and $375 per family and a further $1,000 per covered individual in co-insurance (20 per cent of $5,000 of recognized expenses), Aetna will reimburse all further claims incurred in the year, subject to the provision that they be "reasonable and customary", at 100 per cent. The deductible and co-insurance requirement must be met each calendar year. There is no lifetime reimbursement limit under the Aetna plan. When a participant is treated by a network physician, paying the fixed $10 co-payment for each visit, it is important to note that those $10 amounts do not count towards meeting the $1,000 out-of-pocket expense limit referred to above. This is so because, under the in-network track of the plan, medical expenses are already considered to have been paid at 100 per cent to the network provider after the participant has met the fixed $10 co-pay.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

The package of benefits under the Aetna Open Choice plan is itemized in the plan summary (pp. 12–16). **A fuller description of Aetna benefits is set out in the booklet entitled "Plan Description: Aetna Open Choice Plan for Staff Members of the United Nations".** Copies of this booklet, which every participant should possess, are available from the ICCS office.

In line with the decision to bring the Aetna and Blue Cross plans into greater alignment, certain changes will come into effect on 1 July 1999 with respect to the administration of a number of Aetna benefits, as follows:

Emergency room co-payment. Effective 1 July 1999, there will be a $35 co-payment for the emergency use of hospital emergency room facilities. If the visit to the emergency room results in a hospital admission within 24 hours, the $35 co-payment will be waived. Non-emergency use of the emergency room will be reimbursed at 80 per cent if a network hospital is used, and at 80 per cent after deductible if a non-network hospital is used, as heretofore.

Private duty nursing. With effect from 1 July 1999, private duty nursing will be covered on an in-home basis only (no in-hospital benefit). In addition, the benefit will be limited to $5,000 per year, with a $10,000 lifetime maximum.

Hospital pre-registration. Heretofore, under the Aetna PPO plan, hospital pre-registration (or pre-certification, as it may be designated) has applied to in-patient hospital, skilled nursing facility, hospice care admissions as well as home health care and private duty nursing when the attending physician was a network provider. In this case the network provider was responsible for making the registration telephone call. At the same time, there was no pre-registration requirement if the attending physician was not a network provider. Effective 1 July 1999, all hospital admissions as well as the other services cited above will require pre-registration, though without financial penalty for failure to pre-register. The reason for this change is a constructive one. Pre-registration assures the patient (a) that all related hospital expenses will be covered under the plan, and most importantly that (b) a hospitalization case is medically monitored from the first day of admission, so that if complications should arise, or if after-hospital care should be required, the case may be managed promptly and effectively.

Non-network prescription drug reimbursement. Experience has shown that the majority of Aetna subscribers use the discount prescription drug facility, whether at a pharmacy or by mail-order, to their benefit as well as to that of the plan. Every national and regional drugstore chain belongs to the network, as do thousands of individual pharmacies. However, a sufficient number of participants do not avail themselves of the benefits of the prescription drug programme, with the result that the plan incurs additional and unnecessary costs amounting to several hundred thousand dollars per year. Therefore, with effect from 1 July 1999, non-network prescription drugs will be reimbursed at the rate of **60 per cent** (40 per cent co-insurance), after deductible. In addition, the 40 per cent co-insurance which is the responsibility of the participant will **not** count towards meeting the annual out-of-pocket limit of $1,000. All prescriptions filled at pharmacies outside the United States will continue to be reimbursed at 80 per cent after deductible. However, the co-insurance will not count towards fulfilment of the annual $1,000 out-of-pocket limit.

Aetna claims

The address to which Aetna claim forms should be sent is as follows:

Aetna Life Insurance Company
Unit 73
3541 Winchester Road
Allentown, PA 18195-0501

AETNA OPEN CHOICE SUMMARY OF BENEFITS

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE Individual Family	$0 $0	$125 $375
CO-INSURANCE (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
OUT-OF-POCKET LIMIT Individual Family	N/A	$1,000 $3,000 (network and prescription drug co-pays do not count toward the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	Unlimited
CLAIM SUBMISSION	PROVIDER files claims	YOU file claims
HOSPITAL SERVICES AND RELATED CARE		
COVERAGE In-patient Coverage Out-patient Coverage	100% 100%	
MANDATORY PRE-REGISTRATION (1-800-333-4432) Applies to in-patient hospital, skilled nursing facility, home health care, hospice care, and private duty nursing care	Provider responsible	Subscriber or provider responsible
(FOR EMERGENCY ADMISSION, CALL WITHIN 48 HOURS OR NEXT BUSINESS DAY IF ADMITTED ON WEEKEND)		
Hospital Emergency Room Based on symptoms, i.e. constituting a perceived life threatening situation	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)	100% including physician's charges after $35 co-pay (waived if admitted within 24 hours)
Hospital Emergency Room for non-emergency care (examples of conditions: skin rash, ear ache, bronchitis, etc.)	80%	80% after deductible
Ambulance *[There are no network providers for these services at the present time.]*	100%	
Skilled Nursing Facility 365 days per year	100%	

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Private Duty Nursing (in-home only)	100% subject to a $5,000 maximum per year and $10,000 lifetime	
Home Health Care up to 200 visits per year	100%	
Hospice (210 days) plus 5 days bereavement counseling	100% per lifetime	
PHYSICIAN SERVICES (excluding mental health and substance abuse treatment)		
Office Visits for treatment of illness or injury (non-surgical)	100% after $10 copay	80% after deductible
Maternity (includes voluntary sterilization and voluntary abortion, see Family Planning)	100% after $10 copay;	80% after deductible
Physician In-Hospital Services	100%	80% after deductible
Surgery (in hospital or office)	100%	80% after deductible
Second Surgical Opinion	100% after $10 copay	100% after deductible
Anesthesia	100% (if participating hospital)	80% after deductible
Allergy Testing and Treatment (given by a physician)	100% after $10 copay	80% after deductible
Allergy Injections (not given by a physician)	100%	80% after deductible
Other Physician Services (e.g. emergency room physician who does not bill through hospital)	100%	80% after deductible
PREVENTIVE CARE		
Routine Physicals and Immunizations Children age 19+ and adults: one routine exam every 24 months. Age 65+: one routine exam every 12 months	100% after $10 copay	80% after deductible
Well-Child Care and Immunizations Well-child care to age 7. One exam Every 24 months for ages 7 to 19.	100%	
Routine Ob/Gyn Exam One routine exam per calendar year including one Pap smear	100% after $10 copay	80% after deductible

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Family Planning - Office visits including tests and counseling - Surgical Sterilization procedures For vasectomy/tubal ligation (excludes reversals)	100% after $10 copay 100%	80% after deductible 80% after deductible
Infertility Treatment - Office visits including testing and counseling - Limited to procedures for correction of infertility (excludes in-vitro fertilization, artificial insemination, G.I.F.T., Z.I.F.T., etc.)	100% after $10 copay 100%	80% after deductible 80% after deductible
Routine Mammogram (no age limit)	100%	80% after deductible 100% if performed on an in-patient basis or in the out-patient department of a hospital
Annual Urological exam by Urologist	100%	80% after deductible
MENTAL HEALTH AND ALCOHOL/DRUG ABUSE SERVICES		
MENTAL HEALTH IN-PATIENT SERVICES (1-800-424-1601) **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% Maximum benefit of 90 days per calendar year	100% after deductible Maximum benefit of 90 days per calendar year
These services are provided under the Focused Psychiatric Review (FPR) programme. Pre-registration of in-patient confinements is required. For in-network services, the network provider is responsible for pre-registration. For non-network in-patient services, either the physician or the participant must pre-register the confinement.		
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% up to 50 visits per calendar year	80% after deductible up to 50 visits per calendar year
Crisis Intervention	100% up to 3 visits per calendar year	80% after deductible up to 3 visits per calendar year
ALCOHOL/DRUG ABUSE **In-patient Coverage** *[The benefit maximum is for network and non-network services combined.]*	100% up to 60 days per calendar year	100% after deductible up to 60 days per calendar year
	2 confinements per lifetime	
Out-patient Coverage *[The benefit maximum is for network and non-network services combined.]*	100% up to 60 visits per calendar year	80% after deductible up to 60 visits per calendar year

PLAN BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
PRESCRIPTION DRUG BENEFITS		
Retail Program (1-888-792-8742) (30-day supply)	100% at participating pharmacies after $15 copay; copay maximum is $15	60% after deductible 40% co-payment which will not count towards $1,000/$3,000 out-of-pocket limit
Mail Order Program (1-888-792-8742) (90-day supply)	100% after $10 copay for up to a 90-day supply from participating mail order vendor	
Prescriptions for both Retail Program and Mail Order Program - when brand name is requested, you pay the copay plus the difference between the brand and generic price, unless the physician specifically prescribes the brand-name drug.		
VISION AND HEARING CARE		
Eye Exam (once every 24 months)	100% after $10 copay	80% after deductible
Optical Lenses (including contact lenses)	80%, deductible does not apply; $100 maximum for any two lenses and frames purchased in a 24 month period	
Vision One Program (1-800-793-8616)	Save up to 65% on frames; up to 50% on lenses; about 20% on contact lenses at participating Cole Vision Centers	
Hearing Exam Evaluation and Audiometric exam	100% after $10 copay	80% after deductible (one exam every three years; exam must be performed by otolaryngologist or state certified audiologist)
Hearing Device *[There are no network providers for these services at the present time.]*	80% copay, deductible do not apply; $750 maximum benefit, one hearing aid per ear every three years	
OTHER HEALTH CARE		
Short-Term Rehabilitation Physical and Occupational Therapy	100%	80% after deductible
Laboratory Tests, Diagnostics X-rays	100%	80% after deductible
Speech Therapy	80%, deductible does not apply (where services are rendered by a participating provider, 100% reimbursement applies after $10 copay)	
Out-patient Diabetic Self-Management Education Program	80%, deductible does not apply *[If services are rendered in a hospital, 100% reimbursement applies with no copay. If rendered in a network doctor's office, 100% reimbursement with $10 copay applies.]*	

PLAN BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Durable Medical Equipment	80%, deductible does not apply *[If services are rendered by a network provider or within a hospital setting, 100% reimbursement applies with no copay.]*	
Acupuncture (for chronic pain treatment only; services must be rendered by a medical doctor or licensed acupuncturist)	100% after $10 copay up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*	80% after deductible up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*
Chiropractic Care	100% after $10 copay up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*	80% after deductible up to a maximum benefit of $1,000/year *[Network and non-network benefits are combined for a maximum of $1,000 per calendar year]*

Eye Examination

An eye examination once every 24 months is covered at 100 per cent after a $10 co-payment if carried out by a network provider, and at 80 per cent after deductible if carried out by an out-of-network provider.

"Vision One" eyecare discount programme

The Vision One programme offers subscribers and covered family members immediate discounts on eyecare needs, including frames, lenses and contact lenses. This programme is an addition to, not a substitute for, the existing optical lens benefit which will be continued as before. The programme is available at over 2,500 locations nationwide, including the optical centres in national retail outlets, such as Sears, JC Penney and Montgomery Ward and many of the Pearle Vision Centers, as well as selected independent providers/offices. To obtain the discounts available under this programme, it is only necessary to show the provider the Aetna identification card at the time of the visit. The provider will apply the discounts to any purchases made and will accept valid prescriptions from any licensed optometrist or ophthalmologist. The Vision One programme may be used as often as desired. As it is simply a discount programme, claim forms are not required. For more details and outlet locations, call Vision One at (800)793-8616, weekdays from 9:00 a.m. to 9:00 p.m. and Saturdays from 9:00 a.m. to 5:00 p.m. A schedule of costs and typical savings is set out below.

Benefits	*Vision One cost*
Frames	
Priced up to $60.00 retail	$16.00
Priced from $61.00 to $80.00 retail	$26.00
Priced from $81.00 to $100.00 retail	$36.00
Priced from $101.00 to $200.00 retail	50%
Lenses — per pair (uncoated plastic)	
Single vision	$28.00
Bifocal	$48.00
Trifocal	$58.00
Lenticular	$98.00
Lens options — per pair (add to lens prices above)	
Standard-Progressive (no-line bifocals)	$50.00
Polycarbonate	$30.00
Scratch-resistant coating	$12.00
Ultraviolet coating	$12.00
Solid or gradient tint	$8.00
Glass	$18.00
Photochromic	$34.00
Anti-reflective coating	$35.00
Transitions	20% off retail
Eye examinations (by licensed independent doctors of optometry)	
Eyeglasses — $33.00	
Contact lenses — $10.00 off normal fee	

Contact lenses (two ways to save on contact lenses)

1. Visit the more than 2,500 locations nationwide and save 20 per cent discount from regular retail prices.

2. Use the Vision One Contact Lens Replacement Programme for additional savings and convenience.

Call (800) 391-5367 for this service.

Dispensing fee

The fee for fitting and dispensing (including unlimited eyeglass adjustments) is only $10.00.

Acupuncture benefits

The Aetna Open Choice plan provides benefits for acupuncture treatment rendered by a medical doctor or licensed acupuncturist, up to a maximum benefit of $1,000 per calendar year. While this benefit will be described in the plan description book to be made available to all participants, the scope of the benefit may be summarized as follows:

Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension headache
- Migraine headache
- Psychalgia
- Neuralgia
- Backache
- Lumbago
- Muscle spasm
- Bursitis

Acupuncture treatment in lieu of anaesthesia has been recognized as a reimbursable procedure by Aetna under the traditional plan. This benefit, as well as all other benefits under the traditional plan, will be maintained under Aetna Open Choice.

Mental and nervous and substance abuse benefits

A. In-patient benefits

All hospitalization for mental and nervous and substance abuse conditions is subject to the Focused Psychiatric Review (FPR) procedure. **Staff members are assured that the FPR programme is conducted in the strictest confidence**. The procedure is as follows:

1. Prior to a non-emergency hospital admission, Aetna must be informed of the intended admission. This is accomplished by placing a telephone call to a toll-free Aetna number (**(800) 424-1601**). The call will be taken by a member of the Aetna FPR team. The telephone call may be placed by the subscriber himself or herself, the attending physician, a family member, or any other person acting for the patient to be hospitalized.

2. The initial information required by Aetna in order to pre-certify the admission includes the subscriber's identification number (payroll index number), the reason for the admission, the physician's name, address and telephone number, the hospital name, address and telephone number, and the scheduled admission date.

3. The FPR specialist then contacts the attending physician to review the information prior to certification of the admission. If the attending physician makes the original call to the 800 number, this step will be accomplished at that time. The FPR specialist certifies a certain number of in-patient days, if appropriate, and develops a plan of regular follow-up visits with the attending physician.

4. An emergency admission, which cannot be pre-certified before the confinement begins, must be called in to the Aetna FPR number within 48 hours of the emergency admission.

B. In-patient mental and nervous and substance abuse care

1. The full cost (semi-private accommodation) of 30 days of hospitalization for the treatment of mental and nervous disorders. Hospital confinements beyond 30 days are reimbursed subject to the normal deductible and co-insurance provisions.

2. The full cost (semi-private accommodation) of 30 days of hospitalization for substance (alcohol and/or drug) abuse detoxification and rehabilitation, limited to two 30-day benefit periods in a lifetime. Continuous confinement of up to 30 days beyond this 30-day limit is subject to the provision under paragraph 3 below.

3. Coverage for up to 30 days of hospitalization for substance-abuse (alcohol and/or drug) rehabilitation after the 30-day hospitalization benefit described in the paragraph above has been exhausted. This benefit is available twice in a lifetime and is applicable only as a continuation of each of the two 30-day hospitalization periods provided under paragraph 2 above.

C. Out-patient mental and nervous and substance abuse care

1. A maximum of 50 out-patient visits per year to a medical doctor engaged in the practice of psychiatry (and, depending on the state in which the provider is licensed, for the services of a psychologist and psychiatric social worker). If treatment is obtained from a network provider, the plan pays 100 per cent of the cost. If the provider does not participate in the PPO network, reimbursement will be at 80 per cent of the reasonable and customary fee level for the area in which the services are rendered, and will be subject to the annual deductible. The 50-visit annual maximum is for network and non-network treatment combined. Co-insurance payments made in respect of out-of-network treatment will not be applied to the $1,000 annual co-insurance maximum.

2. Sixty out-patient visits per calendar year for the treatment of alcoholism or drug abuse diagnosed by a physician. Of these 60 annual visits, 20 may be utilized for the counselling of the patient's family if directly related to the patient's alcoholism or drug abuse.

Discount prescription drug programme (Aetna Pharmacy Management)

A. The Aetna Pharmacy Management (APM) prescription drug programme, along with its mail order affiliate, Walgreens Healthcare Plus, reimburses, at significant savings, the cost of prescription drugs obtained from participating pharmacies and from the Walgreens Healthcare Plus mail order facility.

1. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a specific brand be

dispensed by indicating "Dispense as written" or "DAW", the generic equivalent drug will be provided by the pharmacist, and the discount off the AWP can be as high as 50 per cent, depending on the generic equivalent supplied. The discount for maintenance drugs obtained by mail through the Walgreens Healthcare Plus mail order facility will range from 18 per cent to as high as 50 per cent off AWP depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

2. The procedure under which prescription drugs are reimbursed through the Aetna Pharmacy Management Programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice *along with the Aetna card* (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 30-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) based upon the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

3. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through Walgreens Healthcare Plus mail order facility which will charge a fixed $10 co-insurance. The Walgreens order form supplied with the Aetna card should be utilized for ordering prescription drugs by mail. A new order form will be sent along with the filled prescription.

4. It should be noted that if a participant wishes to receive the brand-name drug even though the physician has not specifically prescribed the brand name, the participating pharmacy will charge a participant 15 per cent of the cost of the brand-name drug, but not more than $15 per prescription. In cases in which a brand-name maintenance drug is ordered through the Walgreens mail order facility even though it has not been specifically prescribed, Walgreens will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

B. As the Aetna prescription drug programme benefit is administered separately by Aetna Pharmacy Management, the annual deductible under the Aetna plan will **not** be applied to prescription drugs obtained at network pharmacies. At the same time, however, prescription drug co-payment expenses will **not** count towards meeting the annual co-insurance limit of $1,000. **Prescription drugs obtained at pharmacies in the United States, but not through network pharmacies, will be reimbursed at 60 per cent and be subject to deductible, commencing on 1 July 1999. In addition, the 40 per cent co-insurance amount will not count towards the annual $1,000 out-of-pocket limit**. Prescription drugs obtained outside the United States will be reimbursed through submission of the standard claim form to the Aetna claims office in Allentown, Pennsylvania. In such cases, the annual deductible will have to be met before reimbursement is made, as well as the 20 per cent co-insurance, which will NOT count towards meeting the annual limit of $1,000.

Other provisions

A. Special conditions apply to certain medical procedures for injury-related dental and cosmetic injury, for convalescent facility expenses and for treatment of temporo-mandibular joint syndrome (TMJ). Participants are advised to consult the Aetna claims office in advance of commencing treatment for these conditions.

B. Certain expenses are not covered under the Aetna plan. These comprise expenses for services or supplies not deemed by Aetna as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Aetna as reimbursable under the plan, Aetna Member Services should be contacted at (800) 784-3991 prior to commencement of treatment. In addition, the Aetna policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Aetna denies a claim in whole or in part, the subscriber will receive a written notice from Aetna. This notice will explain the reason for the denial and the appeal procedure. The request for review must be submitted in writing within 60 days of receipt of the notice. The subscriber should include the reasons for requesting the review and submit the request to the Aetna Allentown Claim Office. Aetna will review the claim and ordinarily notify the subscriber of its final decision within 60 days of receipt of the request. If special circumstances require an extension of time, notification will be given to that effect.

Time limit for filing claims

Subscribers should note that claims for reimbursement must be submitted to Aetna no later than two years from the date on which the medical expense was incurred. **Claims received by Aetna later than two years after the date on which the expense was incurred will not be eligible for reimbursement**.

Annex II

Blue Cross BlueChoice

Plan outline

The Blue Cross BlueChoice PPO plan provides in-network benefits including an extensive network of participating providers covering most medical specialties as well as out-of-network (non-network) benefits. When treatment is rendered by an in-network provider, the only charge to the participant is $10 (except for mental health/substance abuse treatment). On the other hand, the participant may equally be treated by a physician who is not a participating practitioner in the plan. Medical services rendered by non-participating (out-of-network) providers will be reimbursed at 80 per cent subject to deductible and 20 per cent co-insurance.

A network of physicians covering New York City and the New York metropolitan area participate in the BlueChoice plan and accept as payment a fee schedule arranged with Blue Cross. No deductible has to be met, but instead, the participant pays a $10 co-payment for each visit (none for mental health). If, however, a participating physician refers a patient to another provider who is non-participating, the deductible and 20 per cent co-insurance will apply in connection with reimbursement of the cost of the services rendered by the non-participating provider, including mental health providers. A number of diagnostic laboratories are participating providers under the BlueChoice plan. When any laboratory tests are required, it is important that the physician be told to direct the tests to a participating laboratory, if possible. If this is done, the cost of the laboratory test will be paid in full and will not be subject to the normal deductible and co-insurance.

Premiums

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

The package of benefits under the Blue Cross BlueChoice plan is itemized in the plan summary (pp. 25–29). **A fuller description of Blue Cross benefits is set out in the booklet entitled "Empire BlueChoice PPO Plan for the United Nations"**. Copies of this booklet, which every participant should possess, are available from the ICCS office.

In line with the decision to bring the Aetna and Blue Cross plans into greater alignment, certain changes will come into effect on 1 July 1999 with respect to the administration of a number of benefits, as follows:

Deductibles and annual out-of-pocket limit. The annual deductibles and the out-of-pocket limit will be the same as under the Aetna plan. Heretofore, the annual calendar year Blue Cross deductible was $150 per individual and $450 per family. With effect from 1 July 1999, these amounts will be reduced to $125 and $375, respectively. In addition, at the same time, the annual ceiling of $900 for unreimbursed allowable out-of-pocket expenses per year will be raised to $1,000 with a family limit of $3,000. Thus, with effect from 1 July 1999,

after $1,000 in out-of-pocket expenses has been incurred against the reasonable and customary costs of covered medical services, further reimbursement of non-network claims will be reimbursed at 100 per cent of the reasonable and customary costs of covered services. With respect to the new deductibles and out-of-pocket limit, as a transitional measure, no additional co-insurance will be assessed on those who will have reached the $900 out-of-pocket limit by 30 June 1999. By the same token, those participants for whom the $150 annual deductible (or any amount over $125) will have been met by 30 June 1999 will not receive a "refund" of the excess over $125.

Out-patient mental health benefit. The out-patient mental health benefit is modified. Formerly, out-patient visits to a mental health provider required a $25 co-payment if in-network or, if out-of-network, were reimbursed at the rate of 50 per cent after deductible. Effective 1 July 1999, the $25 co-payment requirement is removed and the reimbursement rate for non-network treatment goes to 80 per cent after deductible. At the same, time the maximum allowable number of visits in a calendar year will be 50 instead of 60.

Non-network prescription drug reimbursement. Experience has shown that the overwhelming majority of Blue Cross subscribers consistently use the discount prescription drug facility, whether at a pharmacy or by mail order, to their benefit as well as to that of the plan. Every national and regional drugstore chain belongs to the network, as do thousands of individual pharmacies. **With effect from 1 July 1999, non-network prescription drugs will be reimbursed at the rate of 60 per cent (40 per cent co-insurance), after deductible. In addition, co-insurance (the 40 per cent responsibility of the participant) will *not* count towards meeting the annual out-of-pocket limit of $1,000**. However, all prescriptions filled at pharmacies outside the United States will continue to be reimbursed at 80 per cent after deductible. However, the 20 per cent co-insurance will ***not*** count towards fulfilment of the annual $1,000 out-of-pocket limit.

Acupuncture benefits

Blue Cross covers acupuncture treatment provided by a licensed acupuncturist. Covered diagnoses for treatment by acupuncture include the following types of chronic pain syndrome:

- Tension, migraine headache
- Muscle spasm, psychalgia, neuralgia
- Backache, lumbago, bursitis

BLUE CHOICE PPO SUMMARY OF BENEFITS

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
ANNUAL DEDUCTIBLE Individual Family	 $0 $0	 $125 (effective 1 July 1999) $375 (effective 1 July 1999)
CO-INSURANCE (% at which the plan pays benefits)	100% except where noted	100% Hospital; 80% all other, except where noted
OUT-OF-POCKET LIMIT Individual Family	N/A	$1,000 (effective 1 July 1999) $3,000 (effective 1 July 1999) (network and prescription drug co-pays do not count toward the out-of-pocket limit)
LIFETIME MAXIMUM	Unlimited	Unlimited
CLAIM SUBMISSION	**PROVIDER** files claims	**YOU** file claims
HOSPITAL SERVICES AND RELATED CARE		
COVERAGE **In-patient Coverage** [1] ***(except behavioral health)*** - Unlimited days - semiprivate room and board - Other hospital-provided services, facilities, supplies and equipment - Physical therapy, physical medicine or rehabilitation - up to 45 days per calendar year	 100%	
Out-patient Coverage - Facility charges [1] - Pre-surgical testing (must be performed within 7 days of admission) - Chemotherapy & radiation therapy - Mammography & cervical cancer screening	100%	

[1] Must be pre-registered through Utilization Management Program, except for providers outside the United States. (1-800-982-8089)

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
MANDATORY PRE-REGISTRATION (1-800-982-8089) Applies to in-patient hospital, ambulatory surgery, surgery, skilled nursing facility, home health care, hospice care, and private duty nursing care (in-home only)	Subscriber or provider responsible	
(FOR EMERGENCY ADMISSION, CALL WITHIN 48 HOURS OR NEXT BUSINESS DAY IF ADMITTED ON WEEKEND)		
Hospital Emergency Room - Accidental injury - Sudden & serious medical condition	100% including physician's charges after $35 Copayment (waived if admitted with 24 hours)	
Hospital Emergency Room for non-emergency care (examples of conditions: skin rash, ear ache, bronchitis, etc.)	80%	80% after deductible
Ambulance *[There are no network providers for these services at the present time.]*	Not Applicable	100%
Skilled Nursing Facility (1) - Up to 365 days per calendar year	100%	
Private Duty Nursing (in-home only) (1)	100% subject to a $5,000 maximum per year and $10,000 lifetime	
Home Health Care (2) up to 200 visits per calendar year	100%	
Hospice (1) up to 210 days per lifetime (includes 5 days of bereavement counseling)	100%	
(1) Must be pre-registered through Utilization Management Program , except for providers outside the United States. (1-800-982-8089)		
PHYSICIAN SERVICES (excluding mental health and substance abuse treatment)		
Office Visits	100% after $10 copay	80% after deductible
Maternity Care (includes voluntary sterilization and voluntary abortion)	100% after $10 copay; 100% for voluntary sterilization if performed in-patient or in the out-patient department of a hospital	80% after deductible 100% for voluntary sterilization if performed in-patient or in the out-patient department of a hospital

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
PHYSICIAN SERVICES (cont'd)		
Physician In-Hospital Services	100%	80% after deductible
In-patient Visits	100%	80% after deductible
Surgery	100%	80% after deductible
Anesthesia	100% (if the surgeon is in-network)	80% after deductible
Second Surgical Opinion	100% (if arranged through Blue Cross Medical Management)	80% after deductible (if not arranged through BCMM)
Allergy Testing and Treatment (given by a physician)	100% after $10 copay 100% for testing fees and treatment visits	80% after deductible
Allergy Injections (not given by a physician)	100%	80% after deductible
Other Physician Services (e.g. emergency room physician who does not bill through hospital)	100%	80% after deductible
PREVENTIVE CARE		
Routine Physicals and Immunizations Children age 19+ and adults: one routine exam every 24 months. Age 65+: one routine exam every 12 months	100% after $10 copay	80% after deductible
Well-Child Care (including recommended immunizations) - Newborn baby - 1 in-hospital exam at birth - Birth to 1 year of age - 6 visits - 1 through 2 years of age - 3 visits - 3 through 6 years of age - 4 visits - 7 years until 19th birthday - 6 visits	100%	
Routine Ob/Gyn Exam One routine exam per calendar year including one Pap smear	100% after $10 copay	80% after deductible
Family Planning - Office visits including tests and counseling - Surgical Sterilization procedures For vasectomy/tubal ligation (excludes reversals)	100% after $10 copay 100%	80% after deductible 80% after deductible

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
Infertility Treatment - Office visits including testing and counseling - Limited to procedures for correction of infertility (excludes in-vitro fertilization, artificial insemination, G.I.F.T., Z.I.F.T., etc.)	100% after $10 copay 100%	80% after deductible 80% after deductible
Mammography Screening (no age limit)	100%	80% after deductible 100% if performed on an in-patient basis or in the out-patient department of a hospital
Annual Urological exam by Urologist	100%	80% after deductible
MENTAL HEALTH AND ALCOHOL/DRUG ABUSE SERVICES		
MENTAL HEALTH IN-PATIENT SERVICES (1-800-626-3643) **In-patient Coverage** *[The benefit maximum is for network and non-network services combined..]*	100% Maximum benefit of 90 days per calendar year	100% after deductible Maximum benefit of 90 days per calendar year
Out-patient Coverage *[The benefit maximum is for network and non-network services combined..]*	100% up to 50 visits per calendar year (2)	80% after deductible up to 50 visits per calendar year
ALCOHOL/DRUG ABUSE **NOT IN BLUE CHOICE** **In-patient Coverage** *[The benefit maximum is for network and non-network services combined..]*	100% up to 60 days per calendar year (2)	100% after deductible up to 60 days per calendar year (2)
	2 confinements per lifetime	
Out-patient Alcohol/Substance Abuse (2)	100%	80% after deductible
	Up to 60 outpatient visits which include 20 family counseling visits per calendar year	
(2) Must be pre-registered through Behavioral Health Care Management Program, except for providers outside the United States (1-800-626-3643).		
PRESCRIPTION DRUG BENEFITS		
Prescription Drug Card Program **1-800-839-8442** (Empire Pharmacy Management **1-800-624-5376** (Express Pharmacy Management - Mail Order)	15% Copayment up to a maximum of $15 per prescription; mail order with $10 Copayment	60% after deductible 40% copayment which will not count towards the $1,000/$3,000 out-of-pocket limit ($900 until 31 December 1999

BENEFITS	NETWORK BENEFITS	NON-NETWORK BENEFITS
VISION AND HEARING CARE		
Vision Care (1-800-989-5431)	One exam every 24 months with $5 copayment. $10 copayment for frames. $35 allowance for non-plan eyewear	Not covered
Hearing Aid	No in-network benefit	One exam every three years; (limit $100); one hearing aid per ear every three years
OTHER HEALTH CARE		
Physical Therapy - Up to 45 in-patient visits per calendar year - Up to 30 visits combined in home, office, our outpatient facility	100% in facility $10 copayment (home or office)	80% after deductible Deductible and Coinsurance
	Combined maximum for in-network and out-of-network services	
Other Therapies (occupational, speech, hearing, vision) - Up to 30 visits combined in home, office, oir outpatient facility	100% in facility; $10 copayment (home or office)	Deductible and Coinsurance
	Combined maximum for in-network and out-of-network services	
Out-patient Kidney Dialysis - Home, hospital based, or free-standing facility treatment	100%	
Laboratory Tests, Diagnostics X-rays	100%	80% after deductible
Prosthetic & Orthotics, Durable Medical Equipment	100%	80% after deductible
Medical Supplies	Not Applicable	100% not subject to deductible and coinsurance
Acupuncture	$10 copayment	80% after deductible
Chiropractic Care	$10 copayment	80% after deductible

Discount prescription drug programme (Empire Pharmacy Management)

1. The Blue Cross Empire Pharmacy Management (EPM) discount prescription drug programme is administered by MedImpact. The Empire Pharmacy Management (EPM) programme reimburses at significant savings prescription drugs obtained from participating pharmacies. Under this programme, a retail pharmacy network is provided by Empire Pharmacy Management through MedImpact as well as a mail order facility through Express Pharmacy Services.

2. Significant cost savings are being passed on to participants by utilizing either a participating pharmacy or the Express Pharmacy Services mail order facility. In respect of drugs obtained at participating pharmacies, the discount will be at least 15 per cent off the average wholesale price (AWP) of the drug. If the physician does not request on the written prescription that a brand-name drug be dispensed by indicating "Dispense as written" or "DAW", a generic equivalent drug will be provided by the pharmacist, and the discount off the AWP will average 43 per cent depending on the generic equivalent supplied. The discount for maintenance drugs obtained through Express Pharmacy Services will range from 18 per cent to as high as 50 per cent off AWP, depending on whether or not a generic equivalent to the brand-name drug is provided. (Maintenance drugs are drugs used on a continual basis for the treatment of chronic health conditions.) Whenever a prescription carries the words "Dispense as written" or "DAW", the pharmacist or mail order firm will fill the prescription accordingly and no substitution will be made.

3. The procedure under which prescription drugs is reimbursed through the Empire Pharmacy Management programme is as follows. Written prescriptions for drugs are presented at a participating pharmacy of one's choice **along with the Empire Pharmacy Management card** (a listing of participating pharmacies in the New York metropolitan area may be found in annex VII). The pharmacist will fill the prescription for up to a 34-day supply and charge a co-insurance of 15 per cent (rather than the normal 20 per cent co-insurance) on the discounted price of the drug, but never more than $15 per prescription. No claim form is required for prescriptions filled at participating pharmacies.

4. Prescriptions for maintenance drugs may provide for up to a 90-day supply and are most economically filled through the Express Pharmacy Services mail order facility, which will charge a fixed $10 co-payment per prescription. The Express Pharmacy Services claim form supplied with the Empire Pharmacy Management card should be utilized for ordering maintenance drugs by mail. A new order form will be sent along with the filled prescription. The address and telephone number of the mail order prescription drug facility is as follows:

   Express Pharmacy Services
   P.O. Box 270
   Pittsburgh, PA 15230-9949

   Tel. No. (888) 624-5376

5. It should be noted that if a generic equivalent is available and a participant receives a brand-name drug at his or her request even though the physician has not specified a brand name by indicating "Dispense as written" (DAW) on the prescription, the participating pharmacy and/or the Express Pharmacy Services mail order facility will charge the participant the normal co-payment ($10) in addition to the difference between the cost of the brand-name drug and the allowance for the generic equivalent.

6. As the Blue Cross BlueChoice prescription drug programme is administered separately by Empire Pharmacy Management, the annual deductible under the BlueChoice plan will ***not*** be applied to prescription drugs. At the same time, however, the prescription drug co-payment will ***not*** count towards meeting the annual co-insurance limit of $1,000. Prescription drugs obtained outside the United States or within the United States but not through the Empire Pharmacy Management MedImpact's participating network will be reimbursed through the submission of a claim form to the claims office at the following address:

Empire BCBS (EPM)
Pharmacy Unit
P.O. Box 5099
Middletown, NY 10940-9099

Tel. No. (800) 839-8442

The special claim form to be utilized for this purpose is available in the offices of the Insurance, Claims and Compensation Section, room S-2765. Claims submitted to the claims office will be subject to the annual deductible. Claims for prescription drugs dispensed outside the United States will be reimbursed at 80 per cent after deductible, while claims for prescription drugs dispensed within the United States but ***not*** through the Empire Pharmacy Management programme will be reimbursed at the rate of 60 per cent. In addition, the 20 or 40 per cent co-insurance will ***not*** count towards meeting the annual co-insurance limit of $1,000.

Behavioural health and substance abuse benefits

Under the Blue Cross plan, in-patient care for both the treatment of mental and nervous conditions and substance abuse as well as in-network out-patient treatment by a psychiatrist, clinical psychologist or psychiatric social worker requires prior approval by Behavioural Health Care Management (1-800-626-3643).

Other provisions

Certain expenses are not covered under the BlueChoice plan. These comprise expenses for services or supplies not deemed by Blue Cross as being necessary, reasonable and customary or not recommended by the attending physician. There are also certain exclusions and limitations under the plan. For example, cosmetic surgery and certain experimental or investigational procedures are not covered. If a participant has any question as to whether a medical procedure or service will be recognized by Blue Cross as reimbursable under the plan, Blue Cross should be contacted at (800) 377-5156 prior to commencement of treatment. In addition, the Blue Cross policy contract document is on file in the offices of the Insurance, Claims and Compensation Section and may be consulted and photocopied, as necessary. An appointment should be made for this purpose.

Recourse if a claim is denied

If Blue Cross denies a claim in whole or in part, the subscriber has the right to appeal the decision. Blue Cross will send written notice of the reason for the denial. The subscriber then has 60 days to submit a written request for review. Blue Cross will send a written decision with an explanation within 60 days of receiving the appeal. If special circumstances require more time, Blue Cross can extend the review period

up to 120 days from the date the appeal was received. For a review of a hospital or medical claim, write to:

Empire Blue Cross and Blue Shield
P.O. Box 4606
New York, NY 10163-4606
Attention: Group Accounts

Time limit for filing a claim

Subscribers should note that claims for reimbursement must be submitted to Blue Cross no later than two years from the date on which the medical expense was incurred. **Claims received by Blue Cross later than two years after the date on which the expense was incurred will not be eligible for reimbursement.**

Annex III

Health Insurance Plan of Greater New York/Health Maintenance Organization (HIP/HMO)

Health Insurance Plan of Greater New York (HIP)/New Jersey

The Health Insurance Plan of Greater New York (HIP) has ceased to be available in New Jersey, owing to termination of its operations in that state in late 1998.

Plan outline

The HIP/HMO plan follows the concept of total prepaid group practice hospital and medical care, that is, there is no out-of-pocket cost to the staff member for covered services at numerous participating medical groups in the Greater New York area, including New Jersey and certain areas in Florida. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. Additionally, prescription drugs (a $5 co-payment applies) and medical appliances (in full) are covered when obtained through HIP/HMO participating pharmacies and are prescribed by HIP/HMO physicians or any physician in a covered emergency. HIP/HMO participants may select a physician at a HIP medical centre or from a new listing of neighbourhood affiliated physicians for primary care services. The affiliated physician is visited in his or her private office. Specialty care, however, will continue to be given in a HIP medical centre based upon the referral of the selected affiliated physician. To select a neighbourhood affiliated physician, the HIP participant should call HIP at (800) HIP-TALK. Additional information regarding this expansion of HIP providers will be provided to participants during the annual enrolment campaign and also mailed by HIP to all participants.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the HIP/HMO plan will remain unchanged in the renewal period.

HIP/HMO benefits summary

Type of benefit	*HIP HMO coverage*
Hospital services	Covered in full when authorized by HIP/HMO physician
In-hospital physician's services	Covered in full if rendered by HIP/HMO physician
Private duty nursing	Covered in full when authorized by HIP/HMO physician or by any physician in a covered emergency
Skilled nursing facility	No limit on number of days when care is in lieu of hospitalization. Care must be arranged by HIP/HMO physician
Visits to physician's office/health centre	Covered in full at any HIP/HMO medical centre or if care is rendered by HIP/HMO physician
House calls	Covered in full when authorized by HIP/HMO physician or emergency service programme
Maternity care	No waiting periods. Covered in full when care is rendered by HIP/HMO physician. Prenatal, post-natal and well-baby check-ups are covered in full
Preventive care	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens	Covered in full when care is rendered by a HIP/HMO physician. Eye examinations are covered in full when rendered by a HIP/HMO physician (eyeglasses and hearing aids are excluded)
Mental health services	
In-patient	Covered in full for 30 days per calendar year for mental or nervous disorders
Out-patient	HIP/HMO has its own mental health centres that provide psychotherapy and counselling for adults and children with mental or emotional problems
	Individual, family or group therapy sessions are provided as long as treatment is effective. Intensive psychotherapy is excluded
Alcoholism and substance abuse	
In-patient	Covered in full for up to 30 days in any calendar year in a state-certified alcoholism or substance-abuse treatment facility
Out-patient	Medical services for diagnosis and treatment of alcoholism or substance abuse for a period not to exceed 60 visits in any calendar year. HIP/HMO mental health centres will be used for the out-patient services
Emergency services	
In-area	HIP/HMO has an emergency service programme that is in operation when your medical group is closed. This provides the HIP/HMO subscriber with a 24-hour, 7-day service

Type of benefit	*HIP HMO coverage*
Out-of-area	Hospital service: In-patient — covered in full Out-patient — covered in full, when care is received within 12 hours of onset of illness or within 72 hours (three days) following injury Doctor services — HIP/HMO pays customary and reasonable non-HIP/HMO physician fees for covered emergency illness or accidental injury
Prescription drugs and medical appliances	$5 co-payment for prescription drugs, but not appliances, when obtained through HIP/HMO participating pharmacies. The drugs and appliances must be prescribed by HIP/HMO physicians, or any physician in a covered emergency
Preventive dental care	Annual cleaning and other preventive dental services performed by a HIP dentist. $5 co-payment per service
Grievance procedure	Refer to member handbook sent to subscribers

Annex IV

Kaiser Foundation Health Plan of the Northeast/Health Maintenance Organization

Kaiser plan to be phased out

Owing to the decline in enrolment in the Kaiser/HMO plan over the last few years, which has resulted in a current total enrolment of fewer than 70 participants, it has been decided to discontinue offering the plan after 30 June 2000. In effect, therefore, staff members currently enrolled in Kaiser are receiving 12 months' notice that the **plan will be terminated on 30 June 2000**. In order to be sure that each Kaiser participant is promptly notified and afforded ample time to identify new doctors and other providers, whether in the PPO networks of Aetna and Blue Cross or independently, ICCS will communicate with each participant (active and retired) individually.

Plan outline

The Kaiser Foundation Health Plan is an HMO, providing all medical-related services at Kaiser medical group centres or network affiliates. Services under this plan are accessible to staff members residing in northern Bronx, Westchester County and southern Connecticut. Kaiser health centres accommodate not only physicians' offices but also laboratory, X-ray, pharmacy and mental health services. The costs of necessary emergency treatment obtained outside the covered area are included in the plan coverage. There is no ceiling on the use of authorized services, no deductibles to cover and no insurance forms to complete. The plan coverage emphasizes early detection of medical problems before they become major illnesses.

Premium

The premiums and related percentages of salary contribution are shown on page 2 of the present circular. The high premium increase is largely owing to the high level of losses sustained by Kaiser in the past year. (The premium rates shown have been filed with, and approved by, the State of New York insurance authorities.) The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage (shown as a credit). The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Benefits

Benefits under the Kaiser/HMO plan will remain unchanged in the renewal period.

Kaiser/HMO benefits summary

Type of benefit	*Kaiser HMO coverage*
Hospital services	Covered in full when authorized by a Kaiser physician
In-hospital rehabilitation	60 days of in-patient rehabilitation care per condition provided in a hospital or skilled nursing facility
In-hospital physician's services	Covered in full if rendered or authorized by a Kaiser physician
Private duty nursing	Covered in full when considered medically necessary
Skilled nursing facility	Covered in full for 100 days per contract year when prescribed, arranged and approved by a Kaiser physician
Visits to physician's office/health centre	Covered in full at any Kaiser medical centre nationwide or if rendered by or referred by a Kaiser physician
House calls	Covered in full for a registered nurse or Kaiser physician when medically necessary. Limited to the service area
Maternity care	No waiting period. Covered in full when rendered by a Kaiser physician. Prenatal, post-natal and well-baby check-ups are covered in full
Preventive care:	
Annual physicals, well-baby care, eye examinations, hearing tests, diagnostic X-rays, laboratory tests, immunizations and allergens, twice-yearly preventive dental care	Covered in full when rendered or authorized by a Kaiser physician. Preventive dental care for children under 12 years of age only
Alcoholism treatment:	
In-patient	Covered in full for detoxification only
Out-patient	Covered in full up to 60 out-patient visits per calendar year for the diagnosis and treatment of alcoholism
Mental health services:	
In-patient	Covered in full for 30 days per contract year
Out-patient	Covered in full at Kaiser Medical Center for short-term evaluation or crisis intervention for visits 1–10 per contract year. Visits 11–20 are covered subject to a 25 per cent co-insurance of the Kaiser fee-for-service rate. Visits 21–30 are covered at 50 per cent of the Kaiser fee-for-service rate
Emergency services:	
$25 co-payment	A $25 co-payment will be assessed for emergency care services. Immediate notification to Kaiser required if admitted to a hospital (or within a reasonable period of time if incapacitated). Out-patient emergency care requires 48-hour notification to Kaiser, i.e., within 48 hours after the care is received

Type of benefit	*Kaiser HMO coverage*
In-area	Covered in full for life-threatening conditions for care received in a hospital emergency room. Kaiser must be notified first, if possible, or, if not possible, within 48 hours of treatment
Out-of-area	Covered in full for reasonable charges for sudden onset of an illness or accident requiring immediate attention. Kaiser must be notified within 48 hours
Prescription drugs and medical appliances	$3 co-payment for all prescriptions prescribed by Kaiser physicians and obtained at Kaiser pharmacies. Durable medical equipment is covered in full. Coverage is provided for internal prosthetic devices and for their replacement
Grievance procedure	Refer to member handbook sent to subscribers

Annex V

CIGNA Dental PPO Plan

Plan outline

The design of the CIGNA Dental PPO plan offers staff not only a large network of participating providers in the Greater New York metropolitan area and nationally, but also **two distinct plan options, Option A and Option B**, while retaining a single premium structure. The dual option structure is designed to ensure (a) that staff members have the dental treatment for themselves and their family members provided by a PPO network of dentists, and (b) that those staff members whose dental treatment is not rendered by network (or participating) dentists, will have the option of selecting a track which reimburses on the basis of a percentage of "reasonable and customary" dental fees, in much the same way as do the Aetna and Blue Cross PPO health plans. Please note that the CIGNA ID card does not indicate the option selected. The selection of either Option A or Option B is recorded in CIGNA's database and will be known to a provider at the time that coverage eligibility is checked by the provider's office.

Premium

The premiums and related percentages of salary contribution for the CIGNA plan are shown on page 2 of the present circular. The staff member's contribution, based on the relevant percentage of salary, is not shown directly on the end-of-month payroll statement. The payroll statement shows the total monthly premium for the particular level of coverage involved as a deduction from salary as well as the Organization's subsidy towards the cost of that coverage, which is shown as a credit. The actual out-of-pocket cost of the insurance to the staff member is the difference between the total premium and the organizational subsidy.

Option A:

Option A provides for 100 per cent coverage for most dental procedures without any deductible if the dental treatment is rendered by a dentist participating in the CIGNA provider network (a few dental procedures involving costly materials may require additional payment to the dentist by the participant). The CIGNA participating provider network is nationwide, and includes a total of over 38,000 dentists, with approximately 4,800 in New York State (3,000 in New York City), 2,100 in New Jersey and 700 in Connecticut.

Participants who choose Option A may also visit non-participating (or non-network) dentists and will be reimbursed the CIGNA in-network fee contracted with participating dentists who practice in the same area as the non-participating dentists. If the non-network dentist's fee is higher than the contracted in-network fee, the difference will be payable by the participant. It is important to note that, under the CIGNA plan, there is no single PPO contracted fee schedule. The contracted fee levels vary in accordance with prevailing costs in the different areas in which the dental practices are located. A chart summarizing the Option A benefits and reimbursement levels is set out on page 42.

Option B:

The key feature of Option B is the reimbursement allowance formula for participants who wish to utilize non-network dentists. Under this option, out-of-network dental treatment will be reimbursed at certain percentage levels after an annual deductible of $25 per person or $75 per family has been met. The percentage reimbursement levels apply to the

"reasonable and customary" dental fee levels prevailing in the dentist's zip-code area. Reasonable and customary fee levels are determined by reference to a national database maintained by the Health Insurance Association of America (HIAA). The percentage reimbursement rate depends on the level of dental treatment as follows: 90 per cent for preventive/diagnostic treatment; 80 per cent for major and minor restorative treatment; 70 per cent for orthodontics.

Under Option B, participants may also be treated by in-network dentists. In this case there is no deductible. The reimbursement percentages for preventive/diagnostic care, major and minor restorative treatment and orthodontics are 100 per cent, 90 per cent and 80 per cent, respectively, based on the network provider's contracted fee level with CIGNA. Thus the amount payable by the participant will be the difference between the 90 or 80 per cent reimbursement and the CIGNA contracted PPO fee for the service provided. A chart summarizing the Option B benefits and reimbursement levels is set out on page 40.

Dental treatment outside the United States

Participants who obtain dental treatment outside the United States may file their claims with CIGNA and are eligible for reimbursement on the same basis as a participant who visits a non-participating dentist in New York.

Maximum annual benefits

The annual benefit ceiling is $2,000 per covered person, and is the same for Option A and Option B. There is an additional lifetime allowance of $2,000 for orthodontic treatment, limited to dependent children up to 19 years of age.

Pre-treatment review (pre-determination of benefits)

If a course of treatment can reasonably be expected to involve covered dental expenses of $300 or more, a description of the procedures to be performed and an estimate of the dentist's charges should be filed with CIGNA before the course of treatment begins. The dentist should be sure to include the American Dental Association (ADA) procedure code for each procedure claimed.

CIGNA Worldwide Web site

Access to CIGNA's nationwide network of participating dentists is also available through the Insurance home page of the Insurance, Claims and Compensation Section on the United Nations Intranet. In addition, the CIGNA dental provider directory can be accessed directly from CIGNA's Internet Web site, www.cigna.com/dental.

Benefit summaries

The benefit summaries on pages 42 and 43 highlight the many benefits which are available under the CIGNA Dental PPO plan. A complete description regarding the terms of coverage, exclusions and limitations will become available following implementation of the plan.

How to appeal a claim

If you do not agree with the reason given for denial of your claim in whole or in part, you should write within 60 days to the CIGNA claims office. Be sure you state why you believe the claim should not have been denied and submit any data, questions or comments

you think are appropriate. Your appeal will be reviewed by the office that processed your claim. Any appeal that cannot be resolved by that office will be forwarded to the company's Home Office for review and final decision. You will be notified of the final decision within 60 days of the date your appeal is received, unless there are special circumstances, in which case you will be notified within 120 days. If you are not satisfied with the final decision, and you wish to review the documents pertinent to any appealed claim, you should write to the office that processed your claim.

Benefit exclusions:

The following list, while not necessarily complete, gives examples of benefit exclusions:

- Services performed solely for cosmetic reasons
- Replacement of a lost or stolen appliance
- Replacement of a bridge or denture within five years following the date of its original installation
- Replacement of a bridge or denture which can be made usable according to dental standards
- Procedures, appliances or restorations, other than full dentures, whose main purpose is to change vertical dimension, diagnose or treat conditions of TMJ, stabilize periodontally involved teeth, or restore occlusion
- Veneers of porcelain or acrylic materials on crowns or pontics on or replacing the upper and lower first, second and third molars
- Bite registrations; precision or semi-precision attachments; splinting
- Surgical implant of any type including any prosthetic device attached to it
- Instruction for plaque control, oral hygiene and diet
- Dental services that do not meet common dental standards
- Services that are deemed to be medical services
- Services and supplies received from a hospital
- Charges which the person is not legally required to pay
- Experimental or investigational procedures and treatments
- Any injury resulting from, or in the course of, any employment for wage or profit
- Any sickness covered under any workers' compensation or similar law
- Charges in excess of the reasonable and customary allowances

OPTION A

CIGNA DENTAL PPO SUMMARY OF BENEFITS

Benefits	*In-Network* *		*Out-of-Network* *	
Plan Year Maximum - 1 July 1998 - 30 June 1999 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible	None		None	
Reimbursement Levels	Based on reduced contracted fees		Based on In-Network reduced contracted fees	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care Oral Exams (Two per year) Cleanings (Two per year) Full Mouth X-rays (One complete set every three years Bitewing X-rays (Two per year) Panoramic X-ray (One every three years) Flouride Application (One per year for persons under 19) Scalants (Limited to posterior tooth for a person less than 14/One treatment per tooth every three years) Space Maintainers (Limited to non-orthodontic treatment) Emergency Care to relieve pain	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class II - Basic Restorative Care ** Fillings Root Canal Therapy Osseous Surgery Periodontal Scaling and Root Planing Denture Adjustments and Repairs Extractions Oral Surgery	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class III - Major Restorative Care ** Crowns Dentures Bridges	100%	No Charge	100% of In-Network contracted fee	Remainder of dentist's fee
Class IV - Orthodontia Lifetime Maximum (In addition to the Class I, II and III maximum)	100% $2,000 Dependent children to age 19	No Charge	100% of In-Network contracted fee $2,000 Dependent children to age 19	Remainder of dentist's fee

Pre-treatment review (pre-determination of benefits) is recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.

* The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

** Some dental procedures involving costly materials may require additional payment by the participant to the provider.

OPTION B

CIGNA DENTAL PPO SUMMARY OF BENEFITS

Benefits	*In-Network* *		*Out-of-Network* *	
Plan Year Maximum - 1 July 1998 - 30 June 1999 (Class I, II and III expenses)	$2,000		$2,000	
Plan Year Deductible - 1 July 1998 - 30 June 1999				
Individual	None		$25 per person	
Family	None		$75 per family	
Reimbursement Levels	Based on reduced contracted fees		Based on Reasonable & Customary Allowances	
	Plan Pays	***You Pay***	***Plan Pays***	***You Pay***
Class I - Preventive & Diagnostic Care	100%	No Charge	90%	10%
Oral Exams (Two per year)				
Cleanings (Two per year)				
Full Mouth X-rays (One complete set every three years				
Bitewing X-rays (Two per year)				
Panoramic X-ray (One every three years)				
Flouride Application (One per year for persons under 19)				
Scalants (Limited to posterior tooth for a person less than 14/One treatment per tooth every three years)				
Space Maintainers (Limited to non-orthodontic treatment)				
Emergency Care to relieve pain				
Class II - Basic Restorative Care ***	90%	10%	80% **	20% **
Fillings				
Root Canal Therapy				
Osseous Surgery				
Periodontal Scaling and Root Planing				
Denture Adjustments and Repairs				
Extractions				
Oral Surgery				
Class III - Major Restorative Care ***	90%	10%	80% **	20% **
Crowns				
Dentures				
Bridges				
Class IV - Orthodontia	80%	20%	70% **	30% **
Lifetime Maximum (In addition to the Class I, II and III maximum)	$2,000 Dependent children to age 19		$2,000 Dependent children to age 19	

Pre-treatment review (pre-determination of benefits) is recommended when dental work in excess of $300 is proposed. The dentist deals directly with CIGNA in this regard.

* The $2,000 maximum is for the plan year, whether the provider is in-network or out-of-network, or a combination of the two.

** Subject to plan year deductible.

*** Some dental procedures involving costly materials may require additional payment by the participant to the provider.

Annex VI

World Access

World Access (formerly known as Access America) is a facility available to Aetna and BlueChoice subscribers. The $0.25 per month per subscriber cost of the World Access facility is built into the premium schedule for Aetna and BlueChoice set out on page 2 of the present circular.

World Access provides an international travellers' 24-hour hotline assistance programme for obtaining medical care abroad, or within the United States, when at least 100 miles from one's normal place of residence. Participants who call the hotline numbers below will, where possible, be provided with referrals from a worldwide network of physicians, dentists, hospitals, pharmacies and other medical facilities. In addition, in most cases, World Access will settle the costs of **emergency** foreign hospital admission and treatment. If the emergency hospitalization occurs in the United States and the hospital does not accept the Aetna or the Blue Cross BlueChoice identification cards, World Access will also settle the related costs directly with the hospital and then claim reimbursement directly from Aetna or Blue Cross as the case may be. In the case of hospitalization, World Access medical staff will contact the insured patient's local physician in order to monitor the case and services being received. In the event of an emergency hospitalization in the circumstances described above, it is important that World Access be contacted upon admission to the hospital or, at the latest, before discharge. It should also be emphasized that any hospital bill paid by the participant must be sent to Aetna for reimbursement or Blue Cross, as World Access does not reimburse participants directly.

The hotline numbers are:

(800) 654-1901 (in the United States, Canada, Puerto Rico and the Virgin Islands)

(804) 673-1159 — collect (from Alaska, Washington, D.C. and all other locations), or

Fax No. (804) 673-1179

When contacting World Access, be sure to identify yourself as a United Nations participant. Please state the World Access identification number for the United Nations, which is 2065, in addition to your United Nations index number.

Annex VII

AETNA and Blue Cross Plans: list of participating pharmacies

Set out below are lists of the major participating chain pharmacies under the Aetna and Blue Cross discount prescription drug programmes. The Aetna and Blue Cross directories of participating pharmacies are available at the offices of the United Nations Insurance, Claims and Compensation Section; the Division of Personnel, UNDP; and the Office of Personnel, UNICEF. In addition, if a participating pharmacy is needed while travelling, referral information is available from Aetna ((888) 792-8742) and Blue Cross ((800) 839-8442).

Aetna participating chain pharmacies			*Blue Cross participating chain pharmacies*
New York	*New Jersey*	*Connecticut*	
AARP Phcy Service	ACME Phcy	AARP Phcy Service	A & P Phcy
A & P Phcy	A & P Phcy	A & P Phcy	Brooks Phcy
Brooks Drug	Brooks Drug	Arrow Prescription Ctr	Costco
Costco Phcy	Clover Phcy	Arthur Drug Stores	CVS
CVS	Costco Phcy	Brooks Drug	Drug Mart
Drug Mart	CRX Phcy	Costco Phcy	Duane Reade
Drug World	CVS	CVS	Eckerd
Duane Reade	Drug Fair	Douglas Drug	Edwards
Edwards Phcy	Drug World	Edwards Phcy	Finast
Fay's	Duane Reade	F & M Distributors	Foodtown
Finast Phcy	Eckerd Drugs	Genovese	Freddy's
Freddy's	Food Town Phcy	Grand Union Phcy	Genovese
Genovese	Foodmax Phcy	K Mart Phcy	Grand Union
Grand Union Phcy	Genovese	The Medicine Shoppe	JC Penney Prescription Ctr
Great American Drug	Grand Union Phcy	NPSC/EPIC	K Mart
K Mart Phcy	Happy Harry's	Pathmark Phcy	Phar-Mor
King Kullen Phcy	K Mart Phcy	Purity Phcy	Pharmhouse
Kinney Drugs	The Medicine Shoppe	Rite Aid	Price Chopper
Leroy Phcy	Pathmark Phcy	Shop Rite Phcy	Price Club
The Medicine Shoppe	Phar-Mor	Super X Drug Store	Revco
Pathmark Phcy	Pharmhouse	The RX Place	Rite Aid
Peterson Drug Co.	Quick Check	Stop & Shop	Safeway
Phar-Mor	Revco	Waldbaum's Phcy	Sav-On
Pharmhouse	Rite Aid	Walgreens	Shop'N Save
Price Chopper Phcy	RXD Phcy	Wal-Mart	Shop Rite Phcy
Revco	Sav-On		SupeRx
Rite Aid	Shop Rite Phcy		Target
Rockbottom Phcy	Super X Drug Store		The Medicine Shoppe

Aetna participating chain pharmacies			*Blue Cross participating chain pharmacies*
New York	*New Jersey*	*Connecticut*	
Shop'N Save Phcy	The RX Place		Thrift Drug Store
Shop Rite Phcy	Thrift Drug		Tick Tock Drugs
The RX Place	Thrift RX		Tops
Stop & Shop	Waldbaum's Phcy		Vons
Thrift Drug	Walgreens		Wal-Mart
Tops Phcy	Wal-Mart		Waldbaum's Phcy
Vix Phcy			Walgreens
Waldbaum's Phcy			Weis
Walgreens			
Wal-Mart			
Wegmans Phcy			
Weis Phcy			

Annex VIII

Eligibility and enrolment rules and procedures

1. All staff members holding appointments of three months or longer (or six months or longer for dental coverage) under the 100 series of the Staff Rules whose duty station is New York and who are not enrolled in a Headquarters medical/dental insurance plan may enrol during this annual campaign. Medical insurance provisions pertaining to technical assistance project personnel are set out under Staff Rule 206.4. Staff members holding appointments of limited duration under the 300 series of the Staff Rules, except those who receive a fixed monthly cash amount towards the cost of health insurance, are also eligible to enrol in line with the relevant provisions of administrative instruction ST/AI/395, dated 2 June 1994. Currently enrolled staff members may take the opportunity of the annual enrolment campaign to review their coverage and change from one plan to another, or change their coverage in respect of members of their family. The medical scheme applicable to staff holding appointments of less than three months under the 100 series of the Staff Rules or who hold short-term appointments under the 300 series of the Staff Rules is described in information circular ST/IC/86/44 of 15 September 1986.

2. For enrolment purposes, applicants will be required to present proof of eligibility from their respective personnel or administrative officers attesting to their current contractual status. Eligible family members may also be enrolled at this time, provided that evidence of the status (Personnel Action form) of such family members is presented to the Insurance, Claims and Compensation Section. Interested staff members should carefully review the current status of their family's enrolment, both as to the continued eligibility of their children and/or inclusion of those newly eligible or not covered at present.

3. "Eligible family members" refers to a spouse and one or more eligible children. A spouse is always eligible. A child is eligible to be covered under this scheme until the end of the calendar year in which he or she attains the age of 25, provided that he or she is not married and not engaged in full-time employment; disabled children may be eligible for continued coverage after the age of 25. Complete information regarding these provisions can be found in information circular ST/IC/86/72, entitled "Age limitation on the participation of dependent children in United Nations health insurance schemes".

4. Staff members, particularly those who have no coverage under a United Nations plan or through another family member, are strongly urged to obtain medical insurance coverage for themselves and their eligible family members, especially since the high cost of medical care could result in financial hardship for individuals who fall ill and/or are injured and have no such coverage.

5. **In the case of a staff member married to another staff member, the insurance coverage, whether at the two-person or family level, must be carried by the higher-salaried staff member.** It should also be noted that if one spouse retires from service with the Organization before the other spouse, the spouse who remains in active service must become the subscriber even if the retired spouse had been the subscriber up to the date of retirement and is eligible for after-service health insurance benefits following separation from service.

Enrolment between annual campaigns

6. Between annual campaigns, staff members and their family members may be allowed to enrol in the Headquarters medical and dental insurance plans **only** if at least one of the following events occurs and application for enrolment is made within 31 days thereafter:

(a) In respect of medical insurance coverage, upon receipt of an initial appointment of at least three months' duration at Headquarters under the 100 or 300 series of the Staff Rules or upon appointment under the 200 series of the Staff Rules;

(b) In respect of dental insurance coverage, upon receipt of an initial appointment of at least six months' duration at Headquarters under the 100 or 200 series of the Staff Rules;

(c) Upon transfer to Headquarters from another duty station;

(d) Upon return from special leave without pay, but only under the health scheme in which insured prior to taking leave (see para. 9 below);

(e) Upon assignment to a mission, under certain conditions (see para. 10 below); and/or

(f) Upon marriage, birth or legal adoption of a child for coverage of the related family member;

(g) Upon the provision of evidence that the staff member was on mission or annual or sick leave for the entire duration of the annual campaign, staff members may enrol within 31 days of their return to Headquarters.

7. In all the cases cited in paragraph 6 above, the completed application for enrolment or re-enrolment must be certified by the appropriate personnel or administrative officer and received by the Insurance, Claims and Compensation Section within 31 days of the occurrence of the event giving rise to entitlement to enrol. Applications and inquiries with regard to changes relating to such events occurring between campaigns should be directed to the Insurance Section as follows:

Insurance, Claims and Compensation Section
Office of Programme Planning, Budget and Accounts
Room S-2765
United Nations Headquarters
New York, NY 10017

8. **Applications between enrolment campaigns based on any other circumstances or not received within 31 days of the event giving rise to eligibility will not be receivable by the Insurance, Claims and Compensation Section and will be returned.** In this regard, it should be noted that termination of health insurance coverage under a scheme not offered by the United Nations will in no case give rise to any right on the part of a staff member or family member to immediate enrolment in a United Nations plan. If such termination occurs between annual enrolment campaigns, the staff member must wait until the next campaign to enrol in a United Nations plan. Staff members who for any reason may be uncertain about the continuity of their outside coverage are urged to consider enrolling in a United Nations scheme during the present campaign.

Staff on special leave without pay

9. Staff members who are granted special leave without pay are reminded that they may retain coverage for medical and dental insurance during such periods or may elect to discontinue such coverage for the period of the special leave:

(a) *Insurance coverage maintained during special leave without pay.* If the staff member decides to retain coverage during the period of special leave without pay, the Insurance, Claims and Compensation Section **must** be informed directly by the staff member of his or her intention at least one month in advance of the commencement of the special

leave, in person if at Headquarters, or in writing if stationed away from Headquarters. At that time, the Insurance, Claims and Compensation Section will require evidence of the approval of the special leave, together with payment covering the full amount of the cost of the coverage(s) retained (both the staff member's contribution as well as the Organization's share, since no subsidy is payable during such leave);

(b) *Insurance dropped while on special leave without pay.* Should a staff member decide not to retain insurance coverage(s) while on special leave without pay, no action is required upon commencement of the special leave;

(c) *Re-enrolment upon return to duty following special leave without pay.* Regardless of whether a staff member has decided to retain or drop insurance coverage(s) during a period of special leave without pay, it is essential that he or she re-enrol in the plan(s) with the Insurance, Claims and Compensation Section upon return to duty, in person if at Headquarters, or in writing if away from Headquarters. This must be done within **31 days of return to duty**. Failure to do so will mean that the staff member will be unable to resume participation in the insurance plan(s) until the next annual enrolment campaign in the month of June.

Staff members assigned on mission

10. In view of the large number of staff members who go on mission assignment, a special medical/dental plan enrolment opportunity is extended to such staff members. The provisions in this respect, which will apply to all staff members going on mission for six months or more, are as follows:

(a) Staff members who at present are **not** enrolled in any United Nations health insurance plan will be allowed to enrol themselves and eligible family members. The insurance will become effective on the first day of the month in which the mission assignment commences. Enrolment in a health insurance plan in these circumstances must be completed **prior** to the departure of the staff member on mission assignment;

(b) Staff members assigned to a mission who are enrolled in either HIP or Kaiser, two plans which do not offer full services at locations away from Headquarters, may switch to either Aetna or BlueChoice. These two plans provide benefits on a worldwide basis. Enrolment in the Aetna or BlueChoice plans under this provision must be completed **prior** to the departure of the staff member on mission assignment;

(c) Staff members who, at the time of commencement of the mission assignment, do not have dental coverage but who are already enrolled, together with eligible family members, in Aetna or BlueChoice, may enrol themselves and family members covered under their medical insurance plan in the dental plan. Such enrolment must be completed **prior** to the departure of the staff member on mission assignment;

(d) Staff members who elect to enrol in a health insurance plan in the circumstances provided under subparagraphs (a) to (c) above forgo the right to make any further change during the annual enrolment campaign taking place in the same calendar year as the commencement of the mission assignment. The next opportunity for these staff members to make any change in their insurance coverage will be at the time of the annual enrolment campaign of the following year;

(e) Staff members who are already enrolled in Aetna or BlueChoice at the time of the mission assignment must retain their existing coverage until the next annual enrolment campaign;

(f) Staff members who will be on mission assignment for six months or more **and who will not have eligible covered family members residing in the United States** for the duration of the mission assignment may opt for coverage under the Van Breda Medical, Hospital and Dental Insurance plan for staff overseas. Details of this plan are available in the offices of the Insurance, Claims and Compensation Section, room S-2765;

(g) Staff members returning to Headquarters from mission assignment, other than those who qualified and opted for the Van Breda plan, may not change their insurance coverage until the next annual enrolment campaign. **Staff members who switched to the Van Breda plan, as provided under subparagraph (f) above, must revert, upon return to Headquarters, to the insurance plan that they had prior to the mission assignment, at least until the next annual enrolment campaign.** It is essential that such staff members advise the Insurance, Claims and Compensation Section within 31 days of their return to Headquarters. **Failure to re-enrol in the prior Headquarters plan within 31 days of return to duty from mission assignment will result in suspension of health insurance coverage.**

In all cases, staff members going on mission assignment who wish to enrol in a health insurance plan or change their present coverage, as provided above, must present evidence to the Insurance, Claims and Compensation Section of the mission assignment and its duration.

Annex IX

Insurance carrier addresses and telephone numbers for claims and benefit inquiries

I. Aetna Open Choice Plan (medical and out-of-network pharmacy claims)	Aetna Life Insurance Company Unit 73 3541 Winchester Road Allentown, PA 18195-0501
Tel.: (800) 784-3991	Member Services (benefit/claim questions)
Tel.: (888) 792-8742	Participating pharmacy referral
Tel.: (888) 792-8742	Walgreens Customer Service (mail order drugs)
Tel.: (888) 792-8742	Maintenance drug automated refills (credit card)
Tel.: (800) 424-1601	Focused Psychiatric Review (FPR)
Tel.: (800) 793-8616	Vision One
II. Blue Cross BlueChoice Plan	Empire Blue Cross 622 Third Avenue New York, NY 10017
Tel.: (800) 377-5156	Member Services (benefit/claim questions)
(800) 342-9816	Member Services (for faster access)
Tel.: (800) 982-8089	Utilization Management Program (pre-certification for hospital admissions, elective surgery, home care, skilled nursing facilities, second opinion referrals)
Tel.: (800) 626-3643	Behavioral Health Care Management Program (prior approval of mental health/substance abuse care)
Tel.: (888) 624-5376	Express Pharmacy Services, Inc. (maintenance drug mail order)
Tel.: (800) 839-8442	Empire Pharmacy Management Program/MedImpact (prescription card programme and pharmacy network information)
Tel.: (888) EYE-BLUE ((888) 393-2583)	Davis Vision (vision care programme)
III. HIP/HMO Tel: (800) HIP-TALK ((800) 447-8255)	HIP Member Services Department 7 West 34th Street New York, NY 10001

IV. Kaiser/HMO
Tel.: (800) 305-1998
or (888) 247-4500

Kaiser Foundation Health Plan
210 Westchester Avenue
White Plains, NY 10604

V. CIGNA Dental PPO Plan
Tel.: (800) 355-5965
(claim submission and Customer service)

Tel.: (888) DENTAL8
(for participating provider referrals)

Cigna Healthcare Service Center
P.O. Box 182539
Chattanooga, TN 37422-7539